



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

BRAZOS VALLEY EMERGENCY  
PO BOX 2283  
MANSFIELD, TX 76063

#### **Respondent Name**

STATE OFFICE OF RISK MANAGEMEN

#### **Carrier's Austin Representative Box**

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#### **MFDR Tracking Number**

M4-12-1987-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Pt presented to the ER as selfpay, we did not received the WC info till 12/6 when the wife phoned in with this info. We filed claim on 12/21/11 but denied for timely filing, we filed recon 1/16/12 with supporting documents but claim still denies for timely filing."

**Amount in Dispute:** \$110.60

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The Office received a bill on 8/8/2011 as confirmed by the Fax date stamp for date of service 5/21/2011 billing in the amount of \$860.00, upon review the submission from the providers billing agent Financial Control Services it was determined that the bill was not submitted to the carrier on the correct form pursuant to Division rules (Exhibit 1). The bill was returned to the provider on 8/16/2011 stating that the bill as on the wrong form and please completes the required billing form. The Office received a complete clean claim on 12/27/2011, 215 days from the date of service, an audit was processed and denied for 29-time limit for filing has expired. A request for reconsideration was received on 1/19/2012; an audit was processed and denied for 29-time limit for filing has expired. The Office finds that the original submission of the bill for date of service 5/21/2011 was received on August 8, 2011. The provider was aware of the correct carrier on or before 8/8/2011 and not on 12/21/2011 as the provider indicates on the table of disputed services, which states that after receiving a call from the injured employee's wife stating that this service was for worker's compensation injury.

**Response Submitted by:** N/A

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2011	99285, 93010	\$110.60	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of Workers' Compensation Specific Services provided on or after March 1, 2008.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 20, 2012

- 29-The time limit for filing has expired.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

Explanation of benefits dated January 05, 2012

- 29- The time limit for filing has expired.
- 16-Claim/Service lacks information which is needed for adjudication. Remark codes whenever appropriate.

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

### **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided." The requestor states in their position statement that per the instructions of the patient they filed the original bill to the patient within the 95 day timely filing limit. However, billing the patient is not one of the exceptions listed in Texas Labor Code §408.0272. No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	05/21/2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**